Implementation of the Brazilian National Health System permanent negotiating tables in state and municipal health secretariats[1]

Implantação das mesas nacionais de negociação permanente do Sistema Único de Saúde em secretarias estaduais e municipais de saúde

Carinne Magnago
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: carinne.mag@gmail.com

Celia Regina Pierantoni
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: cpierantoni@gmail.com

Swheelen de Paula Vieira
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: helen.nut@gmail.com

Tania França
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: taniafranca29@gmail.com

Rômulo Gonçalves Miranda
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: rnutricao@gmail.com

Dayane Nunes Nascimento
Universidade do Estado do Rio de Janeiro. Instituto de Medicina Social. Rio de Janeiro, RJ, Brazil.
E-mail: day.uerj@gmail.com

Abstract

This article aimed to evaluate the implementation status of the permanent negotiating tables and to identify the obstacles and the advances that have elapsed from the negotiation processes in the Brazilian states and cities. It was a descriptive and exploratory study of national scope. The data collection took place in 2012 and 2013, through a survey of 519 health managers and focus groups with 49 managers and 11 members of the National Permanent Negotiating Table. Data were analyzed by descriptive statistics and by content analysis. We identified 132 negotiating tables, of which only 87 are in operation. The main reasons for not deploying the tables are the lack of technical advice and the use of other tools for negotiating labor. The main changes in work relationships because of the negotiating tables were the holding of public tenders and selective processes, work valuation policies and the implementation of careers and salary plans. We concluded that despite the potential of the tables as negotiating devices, their implementation and full operation face great challenges.

Keywords: Human Resources for Health; Negotiating; People Management; Public Health Policies; Work.

Correspondence
Celia Regina Pierantoni
Rua São Francisco Xavier, 524, bloco E, 7 andar, sala 7010,
Maracanã. Rio de Janeiro, RJ, Brazil. CEP 20550-900.

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Resumo

O objetivo deste artigo é avaliar a implantação da mesa de negociação permanente e identificar os entraves e os avanços decorridos dos processos de negociação no âmbito dos estados e dos municípios brasileiros. O método usado foi estudo descritivo e exploratório, de abrangência nacional. A coleta de dados se deu em 2012 e 2013, por meio de *survey* com 519 gestores de saúde e grupos focais com 49 gestores e 11 integrantes da Mesa Nacional de Negociação Permanente. Dados foram analisados por estatística descritiva e por análise de conteúdo. Verificou-se existência de 132 mesas de negociação, das quais apenas 87 estão em funcionamento. Os principais motivos para não implantação das mesas são a falta de assessoria técnica e a utilização de outras ferramentas para negociação do trabalho. As principais mudanças nas relações de trabalho em decorrência da atuação das mesas de negociação foram a realização de concursos e de processos seletivos públicos, políticas de desprecarização do trabalho e a implantação de planos de cargos, carreiras e salários. Conclui-se que apesar da potencialidade das mesas como dispositivos de negociação, sua implantação e seu pleno funcionamento esbarram em grandes desafios.

Palavras-chave: Recursos Humanos em Saúde; Negociação; Gestão de Pessoas; Políticas Públicas de Saúde; Trabalho.

Introduction

In 2003, the creation of the Secretariat of Labor and Education Management for Health (SGTES), as the main federal instrument for the mobilization of labor management and health training policies, inaugurated a favorable moment for discussion of human resources for health (HRH) issues.

Given the challenges for the labor management in health, it was identified as decisive the need to establish a political support partnership for technical functions that would become strategic structures for the management of the Brazilian National Health System (SUS), efficient and structured, in order to contribute to the equation of the problems of the health sector (Brasil, 2006a).

As a result of this diagnosis, the Qualification and Structuring Program of Labor and Education Management in SUS (ProgeSUS) was born, with the objective of structuring the health secretariats and supplying them with tools to assist in the organization and professionalization of labor management, aiming at the best quality of health services and actions (Dau; Cerca, 2012). ProgeSUS was structured through four components: Structuring of Labor and Education Management in SUS; Management Information System for the Work and Education Management Sector in SUS; Training of the Labor and Education Management Team in SUS; National System of Information in Labor Management SUS - InforSUS. The first component was proposed to specific groups of cities, whose criterion was related to the number of public health posts, with membership conditioned to the presentation of a Structuring and Qualification Plan of the Labor Management and Health Education Sector. The other components, however, were intended for all secretariats that expressed an interest in joining the project (Brasil, 2006b).

In this movement, collective bargaining within the scope of SUS is presented with one of the management tools driven by ProgeSUS, a process raised as a point of agenda in the SGTES after the reactivation of the National Permanent Negotiating Table (MNNP), whose objective is to guarantee

a democratic, institutional and parity space for negotiation in the scope of work issues in SUS.

The negotiation of health work can be understood as a political dialogue and, as such, should be an integral part of the decision-making processes, contributing to the development or implementation of changes in labor management policies in SUS (WHO, 2015).

In this perspective, the negotiating table is an important management tool capable of intervening in a positive way in the effectiveness of the services provided to users, since it seeks the mediation of conflicts and the resolution of the problems faced in the day-to-day work in SUS. To this end, it is structured as a forum at the municipal, state, regional and national levels, based on the constitutional principles of legality, publicity and freedom of association, which brings together managers, health service providers and syndicates representing health workers (Brasil, 2012).

In this context, and considering the need to present subsidies for the advancement of the culture of work negotiation, this study aimed to evaluate the implementation of permanent negotiating tables in states and cities adhering to ProgeSUS and to identify the obstacles and the advances that have elapsed from the negotiation processes.

This study derives from research demanded by the SGTES in order to know the structure and teams of the sectors of labor management and health education to propose the continuity of related policies, which was based on other national studies (Brasil, 2004; UERJ, 2004, 2006, 2008). It is, therefore, an idealized research carried out in a dialogical perspective between the academy (researchers) and political decision makers.

Method

It is an exploratory, qualitative-based, national-level research that has adopted a multimethod strategy in view of the complexity of evaluating national public policies, whose purpose is to produce evidence, gather and systematize data and information that contribute to the Improvement of the political actions analyzed here (Jannuzi, 2014).

Data collection took place in two stages. In the first one, a survey was conducted for those responsible for the area of HRH in the municipal and state health secretariats (SMS and SES, respectively) who joined ProgeSUS until October 2011. For the survey of these structures, a list of cities contemplated by ProgeSUS provided by the Department of Health Management and Regulation (Departamento de Gestão e Regulação em Saúde – DEGERTS/SGTES) was used, and 644 health departments were collected, corresponding to the sample universe of this research.

For the elaboration of the survey work meetings were held between the researchers and the DEGERTS technical team. The main variables of the study that allowed us to fulfill the purposes of the research were defined based on previous researches in SES (Brasil, 2004) and SMS (UERJ, 2004, 2006, 2008). Thus, a questionnaire was elaborated, with 56 questions, divided into nine blocks: respondent profile and hierarchical organization of the health secretariat; adherence to ProgeSUS; job plan, careers and salary; performance evaluation; deprecarization of work; budget/financing; health education; initiatives and tools; and work negotiating table, focus of this manuscript.

The questionnaire was structured in an electronic form and applied remotely through computer-assisted telephone interviews (ETAC) between July and September 2012, and 519 interviews were completed (81% of the sample universe), including all SES (n=27) and SMS of capitals (n=26), and 466 SMS from other cities.

In the second stage, focus groups were held to deepen the topic of "work negotiation in SUS." Five focus groups were conducted with HRH managers from five Brazilian regions, totaling 49, from June 2012 to April 2013. The focus groups were held at the Regional Labor Management Meetings promoted by the Ministry of Health with the purpose of establishing a group of health work managers to share experiences from different cities and states, discuss problems and collective interventions, present and discuss the health labor management policies, in the view of the three governmental spheres. A focus group was also composed of 11 representatives of the workers who make up

the MNNP of the SUS, held during the 57th MNNP Ordinary Meeting, held on August 15 and 16, 2012, in Brasilia.

For conformation of the groups the number of participants between six and fifteen people was considered, as recommended in the literature (Backes et al., 2011). The groups, which lasted an average of 67 minutes, were carried out by two researchers: one assumed the position of mediator of the group, directing the discussion according to the seven triggering questions contained in a script elaborated specifically for the focus group, while the other one was responsible for enter and record group discussions in real time, using Mp4 type digital equipment.

The triggering questions had to understand the role of work negotiating tables, the greatest difficulties and the progress made in the negotiation process, in order to amplify the evidence on the subject and to subsidize proposals of technical support of the Ministry of Health in the implementation and/or maintenance of trading venues.

The data from the first step were stored in a computerized database in Microsoft Office Excel spreadsheets® and Statistical Package for the Social Sciences (SPSS)® and treated by descriptive statistics. The information of the second stage was transcribed integrally and submitted to content analysis, with the purpose of producing inferences. To do so, the following steps were used: (1) pre-exploration of the material produced in the interviews, through a reading that allowed the organization of content relevant to this study; (2) selection of the units of analysis, that is, highlighting cut-outs of the statements whose meanings, together, could give context to the inferences undertaken by the researcher, without concern for establishments of categories of analysis; (3) interpretation of data and discussion based on related theoretical reference (Cavalcante; Calixto; Pinheiro, 2014).

In accordance with ethical standards for research involving human subjects, the study was submitted to the Research Ethics Committee of the Instituto de Medicina Social of Universidade do Estado do Rio de Janeiro, and was approved with CAAE no. 0038.0.259.000-11.

Profile of the analyzed secretariats and managers interviewed

Of the 519 investigated secretariats, 202 (39%) are located in the Southeast region, 311 (60%) in cities with up to 100 thousand inhabitants and 155 in cities in the range of 100 to 500 thousand inhabitants. The organs in the area of labor management and health education are mostly subordinate to the health secretariat (66%), located in the second (26%) or third (20%) echelon of the secretariat's organizational chart. The managers of this body are, for the most part, women (61%), with up to five years in the secretariat (45%).

Implementation and situation of the permanent negotiating tables

We identified the existence of 137 tables, which corresponds to 26.4% of the institutions surveyed. Of these, however, only 87 are in operation. Analyzing the data by type of health secretariat, it was observed that 74% (n=20) of the SES and 65% of the capital SMS have a table. It is worth mentioning that the sum of the managers who do not know about the existence of a table with those who do not know what the table is corresponded to slightly more than 20% of the respondents, according to Table 1.

Regarding the main reasons for the non-implementation of the table in the 226 secretariats that do not have it installed, the following stand out: the lack of technical advice for the implementation (31%), the fact that the secretariat already uses another tool for negotiating the labor (21%), use of other trading instruments (14%) and the lack of interest of managers (13%) and workers (8%).

Of the secretariats that already use another tool for work negotiation in the SUS, most (10%) practice negotiation within syndicates.

The stratification by type of secretariat does not alter to a large extent the exposed scenario. The absence of technical advice was also the most reported reason for not installing the table in the scope of SES (67%), SMS capital (20%), with equal percentage for the lack of interest of managers and use of another tool, and SMS (31%).

Among the implanted negotiating tables (n=137), 56% do not have approved internal rules of operation. Considering the stratification by type of secretariat, 60% of SES and 62% of capital SMS have approved internal regulations, while the percentage of SMS was only 36% (n=37).

The most cited institutions as participants were: syndicates (69%) and health secretariats (65%), according to Table 2.

The study pointed out that the largest number of SES and SMS capitals tables was implemented between 2003 and 2008. Among the SMS, we observed a higher concentration in the period from 2009 to 2011 (39.4%). Regarding the scope, 45% (n=61) of the tables are specific to the health sector, the others are of general scope, with joint negotiation for all sectors of the state/city.

The analysis by type of office indicated that SES and SMS capitals have higher percentages (55% and 77%, respectively) of specific tables for the health sector, while in the SMS the results indicate a balance between the existence of specific tables for health and general tables.

Table 1 – Implementation and situation of permanent negotiating tables in health secretariats investigated, Brasil, 2012

Table situation	State secretariats		Capital secretariats		Municipal secretariats		Total	
	N	%	N	%	N	%	N	%
Non-implanted	3	11.1	10	38.5	213	45.7	226	43.5
Implanted and working	13	48.1	9	34.6	62	13.3	84	16.2
Not aware	1	3.7	1	3.8	73	15.7	75	14.5
Implanted but not working	7	25.9	4	15.4	42	9.0	53	10.2
In discussion process	1	3.7	2	7.7	42	9.0	45	8.7
Do not know what the table is	1	3.7	0	0	30	6.4	31	6.0
Did not answer	1	3.7	0	0	4	0.9	5	1.0

Source: UERJ, 2014

Table 2 – Institutions participating in permanent negotiating tables, according to type of secretariat, Brasil, 2012

Participating institutions	State secretariats		Capital secretariats		Municipal secretariats		Total	
	N=20	%	N=13	%	N=104	%	N=137	%
Syndicates	14	70.0	10	76.9	70	67.3	94	68.6
Municipal Health Secretariat	3	15.0	11	84.6	77	74.0	91	66.4
Associations of workers	10	50.0	8	61.5	37	35.6	55	40,1
Classes council	9	45.0	4	30.8	36	34.6	49	35.8
Council of Municipal Health Secretariats	9	45.0	5	38.5	26	25.0	40	29.2
State Health Secretariat	14	70.0	4	30.8	21	20.2	39	28.5
Ministry of Health (region)	4	20.0	4	30.8	23	22.1	31	22.6
National Health Service (regional)	4	20.0	4	30.8	16	15.4	24	17.5
National Health Surveillance Agency (regional)	1	5.0	2	15.4	17	16.3	20	14.6
Other	4	20.0	0	0	6	5.8	10	7.3

Source: UERJ, 2014

Influence of negotiating tables in the work relationship

The study also investigated the existence of possible changes in work relationship from the functioning of the negotiating tables: 46.7% of the managers who indicated a table said they had noticed changes, the most notable being the second degree of importance attributed by them, the holding of public tenders, the improvement of working conditions and job, career and salary plans (PCCS).

The degree of importance was attributed by means of Likert scale, which ranged from 1 to 5 (1 being the least important degree). The calculations of the averages indicated, according to the type of office, that, in the scope of the SES, the most important changes were related to the working day (average=4.50) and to competitions (average=4.25), as shown in Table 3.

The study also investigated whether the results of the table pointed to agreements on the issues at hand and it was found among the managers who pointed out changes after table implementation (n=64), that 84% responded positively to this question.

It was also pointed out the existence of other work negotiation spaces, and the most frequently mentioned sites were: health council meetings (n=101; 19%) and meetings with workers (n=83; 16%). It is important to note that for 19% of managers conflicts are not solved in any instance.

Table 3 – Degree of importance of the changes occurred in the area of labor management and health education after implementation of permanent negotiating tables, according to type of office (n=64), Brasil, 2012

Components	Averages of importance by office type		
	State	Capitals secretariats	Municipal secretariats
Conduct of public tenders and selection processes	4.25	4.20	3.88
Disadvantaged work policies	3.43	4.25	3.65
Careers/Salary Plan	4.00	4.20	3.51
Working hours	4.50	3.50	3.45
Work conditions	3.63	3.67	3.58
Social protection	3.00	2.50	3.45
Salary	3.89	3.67	3.41
Performance evaluation	3.11	3.40	3.46
Worker's health	3.29	3.17	3.61
Conflicts resolution in work relationship	3.38	3.50	3.49
Judicial/work issues	2.43	2.40	3.38

Source: UERJ, 2014

Obstacles and advances in the scope of work negotiations in SUS

In the regional focus groups, managers stated that the discussions in the negotiating areas had little impact on changes in the area of labor management, due to the low frequency of meetings and the low density and deepening of the issues due to the lack of knowledge of many participants about the issues approached.

Things go around when you have the table. The Ministry of Health's great importance is to train negotiators. There are many unprepared people ahead of the negotiations (Focus group - managers).

The state negotiating table was very well established and disseminated according to the guidelines of the ministry [...]. *It only lasted a management due to the lack of information of the managers.*

Today is not contributing to management, because it does not work (Focus group - managers).

This scenario is an obstacle to, for example, the design and implementation of a health-specific PCCS. In this regard, questioned about the national guidelines for institution of PCCS under the SUS, approved by the MNNP-SUS, by the Tripartite Interagency Committee and endorsed by the National Health Council, most managers reported to know them superficially.

The lack of interaction among the various actors involved in the area of health labor management was also a point of discussion - a lack which, according to managers, leads to the exclusion of some of these actors from the negotiation process and decision making, which in some cases, the centralization of deliberations.

Another point to highlight was the consensually about the lack of preparation, ignorance and omission of the syndicate representatives. The disagreement between syndicates, managers and government was strongly felt in the discussions concerning the PCCS, which is underfunded by the sector, by lack of technical support from the SES and the Ministry of Health, in the diversification of existing work ties and the "lack of political will."

The "lack of political will" was identified as an obstacle to improvements in the area of labor management and implementation of negotiating tables and PCCS. The prioritization of certain categories by the government has led to specific negotiations to, for example, the implementation of career plans by professional category, generating internal conflicts and greater distance between professions, managers and government. An example of this is the intense discussion, in most Brazilian states and cities, about higher compensation, benefits, programs, and policies unique to physicians.

It should also be pointed out that the change of government and health managers has also been reported as an obstacle to negotiation, since, generally speaking, the processes initiated in previous management are not followed up, since each government prioritizes different aspects and areas.

The entry of social organizations into health was also considered to be an obstacle to the negotiation of work. Health management by a non-public entity generates differences between employees and contractors who, even though they hold the same position, are differentiated in terms of remuneration and benefits - a situation that also makes it difficult to formulate a PCCS.

Notwithstanding the related obstacles, managers agree that the negotiating table is a powerful tool for management and dialogue, and can contribute to the improvement of the various aspects related to work and education in SUS.

The table helps a lot, since the beginning. It is a powerful management tool (Focal group - managers).

Changes in the field of labor management are visible due to the negotiating table. The table is a conflict arena, which exposes the difficulties accumulated over time (Focus group - managers).

Regarding the focus group with representatives of the MNNP-SUS, the starting point of the discussion was the support of the participants that the role of the bureau pervades the implementation of guiding directives on the various instruments and activities related to the management of work and health education rather than decision-making.

The tables are for the establishment of guidelines [...] *that may or may not be incorporated by states and cities.* [...] *The table discusses the need of a political point of view* (Focal group - MNNP).

Our decisions cannot be imposed, just refer to (Grupo focal - MNNP).

The main obstacles to the implementation of the guidelines agreed at the tables mentioned by the participants are (1) the non-regulation of negotiation within the scope of the public service and (2) the non-obligatoriness of managers to adhere to the proposals agreed collectively.

The big discussion is to create a state policy. Mandatory Institutionalize the negotiating process.

*While this is not the case, the managers will do it whenever they want (*Focus group – MNNP).

About the PCCS, the participants listed critical points that delay the advance of this management tool so important for the valorization of the health worker and for the improvement of the quality of the services provided to the users, among them the financial question, which makes difficult the implementation of this tool through the several Brazilian cities, especially those of smaller size.

Every PCCS has a financial impact, and it does not pass by the table. So, any decision should be forwarded to other forums and state bodies that will discuss the financial impact. [...] *The offices* [...] *of health, that have good governance, will decide whether to implement or not, following the logic of financial impact* (Focus Group – MNNP).

In this sense, the multiplicity of existing work relationship, which is associated with the precariousness of work, also constitutes a challenge for the process of negotiation and implementation of careers. Likewise, the lack of a national salary floor for SUS workers was also referred to as an obstacle.

As MNNP-SUS advances, the representatives pointed out: the uninterrupted operation of the table ten years ago; the establishment of national guiding directives and the consequent implementation of 16 PCCs in different cities; the discussion of policies/strategies from the political point of view; and fostering a culture of negotiated management.

Discussion

Before and also parallel to the process of decentralization of the national health system to states and cities are the social and economic transformations, mainly in the field of work. This has become more evident from the process of productive restructuring, characterized above all by the incorporation of technologies and other innovations, aiming for a more flexible organization and management of work (Costa, 2017).

The demands of the national health system, the expansion of jobs, the reconfiguration of management, and the bureaucratic and legal limits imposed for the area of human resources, consequently led to new contractual modalities, which, however, were not led by reforms of inspection and regulatory state models, which, in turn, promote the appropriateness of the legislature that disciplines such modalities (Pierantoni, 2001). This movement brought the aggravation of the precariousness of work, with direct social consequences to the workers.

This scenario has raised the field of health workers' demands, placing relations and working conditions at the center of the discussions, and establishing a dialogical space for political discussion among policy makers, workers and other actors involved in maintaining SUS. From this movement, the MNNP-SUS proposal, established in 1993 (Brasil, 2003), is born.

Prior to this, however, experiences at the local level had already legitimized collective bargaining as a powerful instrument for the democratization of work relationships. The first experience reported in Brazil dates back to 1990, when the Permanent Collective Bargaining System was implemented at the Medical Assistance Institute of the State Public Servants of São Paulo, whose discussions resulted in a change in care flows and reorganization of work (Garcia, 2010).

In spite of the initiatives to regulate the question of the HRH, resistance was experienced in the negotiation spaces that, added to the unfavorable conjuncture for the interlocution with the trade syndicate movement, culminated in the deactivation of the MNNP in 1995 and whose reactivation only occurred two years later, functioning, even if precariously, until 2002 (Dau, 2005).

In 2003, the National Health Council, unanimously approving the resettlement of the bureau, places the conflict negotiations as central to the development of the SUS, signaling to resolve these issues (Brasil, 2003).

Since then, it has been noticed an expansion of the work negotiation policy, given the increase in the number of negotiating tables installed in recent years, as the comparison of these results with previous studies (Pierantoni; Garcia, 2011, 2012). Nevertheless, the high percentage of installed but

not functioning tables points to the challenge of maintaining these democratic negotiating spaces functionally effective.

The democratization of work relationships, which refers to the legitimate guarantee of the participation of workers in the aspects that involve the work process, contributes not only to the valorization of the worker, but also, as a consequence, to the improvement of working conditions and quality of services provided by SUS (Demari, 2007).

The spaces of social participation function as a de-bureaucratic instrument of political discussion, and, as a consequence, of the cycle of development of public policies, that is, of the dynamism of the process over time, whose stages include decision-making and formulation, implementation and subsequent evaluation. This is because it creates a context of cooperation of a dialogical and decisive nature, which considers conflicts as an intrinsic part of the public policy process (Andrade; De Luca; Sorrentino, 2012; Heidemann, 2009).

In this sense, the negotiating tables act as collegiate instances of dialogue that require participants to have political knowledge, labor management processes and negotiation skills, a point mentioned by the participants of this study as a barrier to the conduct of the tables.

This aspect was also pointed out by a study carried out in cities of São Paulo, whose managers interviewed presented contradictions about the understanding of negotiation processes (Junqueira et al., 2011). Similarly, Stephan-Souza et al. (2010) refer that there is an unpreparedness of the managers to reconcile the individual interests with the collective ones, that adds to the low knowledge on the SUS policy.

Other concerns that make it difficult to establish and maintain the tables, as well as make it unfeasible to discuss issues important to the area of labor management, are the lack of regulation of public service negotiation processes and the lack of a national floor for workers in the health area, as indicated by the members of MNNP-SUS. These results corroborate with those found by Silva (2012). According to the author, both managers and workers need to initiate a process of discussion about the establishment of a national isonomic floor for SUS workers and the establishment of a working day for the health sector that is differentiated, considering the particularities of the work of the sector. Regarding the lack of legislation regulating the negotiation process in the public sector, it is urgent to debate and agree, in the MNNP-SUS itself, a bill that regulates this management tool.

There are also the difficulties arising from political resistance in the own governments and disputes over financial resources to make proposals feasible (Pimenta, 2012), as well as the diversity of the worlds of work, where servers and subcontractors coexist, which makes negotiation processes more complex (Fonseca; Vieira, 2011).

Regarding the absence of technical advice, the main reason alleged by managers for the non-implementation of tables SGTES has made an important movement of support and cooperation with the SES and SMS that wish to implement the table, especially through technical visits and training of negotiators within the scope of SUS.

The omission of the syndicate representatives, mentioned by the managers, was also verified by a study by Junqueira et al. (2011), whose results pointed out that the syndicate representatives, as well as the councilors representing users, transfer the prerogative of the formulation of political proposals to the managers, giving up their protagonism and the collective construction.

Negotiation as a management tool should be understood as a process that allows evaluation, analysis and agreement of interests and priorities by the various social actors involved in the health context (Braga, 2002). On the other hand, the process of health negotiation in Brazil encompasses a very complex field, with several institutions and subjects involved and that have their particular interests – sometimes contradictory – which requires perseverance on the part of the negotiators (Souza, 2009).

Final remarks

In view of the scale and complexity of the challenges presented in the field of health labor, reflecting the different areas that structure the SUS,

the need for decision-making processes, design and implementation of public labor management policies in a dialogical perspective.

The processes of democratic negotiation and agreement of goals related to labor management are found in permanent negotiating tables, parity and participatory forums that legitimize the role of health actors. However, in spite of the potentiality of this device, its implementation and operation run into great challenges, as can be ascertained in the results of this research.

The data presented here and the expanded debates on the subject will enable the elaboration and collective construction of aspects related to the management of work in health, in the search for adequate solutions to the limits and potentialities of the federative sphere, especially since it is a research designed and developed collectively between academia and policy makers.

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Authors' contribution

Pierantoni, Vieira, Magnago and França conceived the research project. Vieira, Magnago, Miranda and Nascimento collected the data, which were interpreted by all of the authors. Pierantoni, Vieira and Magnago wrote the article, whose final version was approved by Pierantoni, Magnago, França, Miranda and Nascimento.

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